

# REPORT DOCUMENTATION PAGE

Form Approved  
OMB No. 0704-0188

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1. AGENCY USE ONLY (Leave blank)	2. REPORT DATE APRIL 1995	3. REPORT TYPE AND DATES COVERED
4. TITLE AND SUBTITLE  STUDY OF A PROPOSED CONSORTIUM OF SERVICES		5. FUNDING NUMBERS
6. AUTHOR(S)  CAPTAIN SCOTT W CHILDERS		
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)  US ARMY-BAYLOR UNIVERSITY GRAD PGM IN HCA		8. PERFORMING ORGANIZATION REPORT NUMBER  19A-95
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)  US ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL BLDG 2841 MCCS HRA US ARMY BAYLOR PGM IN HCA 3151 SCOTT ROAD FORT SAM HOUSTON TEXAS 78234-6135		10. SPONSORING/MONITORING AGENCY REPORT NUMBER
11. SUPPLEMENTARY NOTES		
12a. DISTRIBUTION / AVAILABILITY STATEMENT  APPROVED FOR PUBLIC RELEASE: DISTRIBUTION IS UNLIMITED		12b. DISTRIBUTION CODE
13. ABSTRACT (Maximum 200 words)  This paper is a case study of a developing consortium between General Leonard Wood Army Community Hospital (VA), and the University of Missouri Health Science Center (UMHSC). A consortium is one strategy available for use in the ever-present battle to control costs, improve assess, and improve quality.		

DTIC QUALITY INSPECTED 2

19960911 043

14. SUBJECT TERMS  STUDY OF A PROPOSED CONSORTIUM OF SERVICES PROVIDED BY GENERAL LEONARD WOOD ARMY COMMUNITY HOSPITAL, THE HARRY S TRUMAN MEMORIAL VETERAN'S HOSPITAL, AND THE UNIVERSITY OF MISSOURI		15. NUMBER OF PAGES 24
		16. PRICE CODE
17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT
		20. LIMITATION OF ABSTRACT

**STUDY OF A PROPOSED CONSORTIUM OF SERVICES  
PROVIDED BY GENERAL LEONARD WOOD ARMY COMMUNITY HOSPITAL,  
THE HARRY S. TRUMAN MEMORIAL VETERAN'S HOSPITAL, AND THE  
UNIVERSITY OF MISSOURI HEALTH SCIENCE CENTER**

**A Graduate Management Project**

**Submitted to the Faculty of the U.S. Army-Baylor**

**Graduate Program in Health Care Administration**

**In Partial Fulfillment of the**

**Requirements for the Degree**

**of**

**Master of Health Administration**

**by**

**Captain Scott W. Childers**

**April 1995**

## ABSTRACT

This paper is a case study of a developing consortium between General Leonard Wood Army Community Hospital (GLWACH), the Harry S. Truman Memorial Veteran's Hospital (VA), and the University of Missouri Health Science Center (UMHSC). A consortium is one strategy available for use in the ever-present battle to control costs, improve access, and improve quality.

GLWACH and the VA will be able to make agreements under the concept of the Veteran's Affairs and Department of Defense Health Care Resources Sharing Program. This program allows for the sharing of resources to accomplish a specific mission. By effectively utilizing resources contributed from separate organizations, economies of scale and scope may be achieved, while at the same time improving access and maintaining quality. GLWACH and the VA are considering taking this logic one step further by including the UMHSC.

The consortium appears as an attractive alternative for several reasons. First, by working together, limited resources should be utilized more efficiently. Second, it is becoming increasingly difficult for independent organizations to wield enough power to allow them to operate as efficiently as possible. By developing this consortium, a network is being formed that will allow the participating organizations to exert much more influence than they previously could independently. Finally, this agreement can be viewed as a positive step that is responsive to those who question the loyalty of hospitals to the communities they serve.

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## INTRODUCTION

The tumultuous environment the health care industry operates in today requires dynamic actions by health care leaders to maintain viable organizations that are capable of providing quality health care to meet the needs of the community they serve. The purpose of this paper is to provide a case study that describes one potential strategy that the leadership of General Leonard Wood Army Community Hospital (GLWACH) is considering in their continuing efforts to provide this care.

The themes of continuously improving in the areas of cost, quality, and access are omnipresent not only in the Military Health Services System (MHSS), but throughout the industry. Different strategies have been executed throughout the industry to improve in each of these areas. The conjoining of capabilities into a consortium of health care organizations, to provide care to the community, is one such strategy that is being contemplated by GLWACH. This consortium would be designed to meet the health care requirements of customers from each of the participating organizations while serving as a means to develop a seamless continuum of care that takes advantage of differing capabilities that participating organizations have to offer.

Organizations that have been identified for potential participation in this arrangement are GLWACH, located at Ft. Leonard Wood Mo., the Harry S. Truman

Memorial Veteran's Hospital (VA), located in Columbia, Mo., and the University of Missouri Health Science Center (UMHSC), also located in Columbia, Mo.

### STATEMENT OF THE PROBLEM

This study will attempt to answer the question: Why are GLWACH and the VA developing a consortium in conjunction with the UMHSC?

### METHODOLOGY

I have chosen a case study research methodology as a research strategy to study the developing consortium. The case study is appropriate for answering research questions such as how, and why, and in cases such as this, where the researcher has no control over the events surrounding the research subject. Furthermore, this study is contemporary in nature, and according to Yin , the case study is the preferred methodology in this situation (Yin 1989).

Yin defines a case study as an empirical inquiry that meets three criteria.

- (1) it investigates a contemporary phenomenon within its real-life context; when
- (2) the boundaries between phenomenon and context are not clearly evident; and in which
- (3) multiple sources of evidence are used.

Even though a case study methodology is the most appropriate at this time, this subject needs quantitative analysis as soon as practical after it becomes operational.

A potential concern during the study was the possibility that individuals from the VA and the UMHSC will not fully disclose information to me in fear that I, as part of the GLWACH staff, will utilize this information in a way that will provide

GLWACH with the upper-hand in any negotiations. During my interactions with participating organizations, I verbally conveyed my objectivity in an attempt to alleviate any concerns in this area. Throughout my interactions with all participants, I did not get the perception that anyone was withholding information in fear that I would use it to the advantage of GLWACH. All interactions between participants and myself, and between participants themselves, were extremely candid. The atmosphere was one that gave the connotation that everyone must be honest and open with each other in order to make this work.

#### Validity, Reliability and Ethics

Validity in quantitative research depends on the use of an instrument that measures what the researcher thinks he is measuring. Validity in qualitative research is much more difficult because the researcher is the instrument (Patton 1989). Even though validity and reliability are more difficult to maintain in case study research, there are methods to ensure they are not neglected. In this study a combination of techniques were utilized.

By using a combination of techniques to gather data (ie interviews, document reviews and observations), I am able to use different data sources to validate and cross check findings, thereby increasing validity. Additionally, I had the case study report reviewed by key personnel who provided information, in an effort to address construct validity. These key personnel were able to verify the accuracy of the report, and notify the researcher of any inaccuracies identified.

The goal of reliability is for the study to be reproducible with the same results. To address the needs of reliability, I maintained a case study data base. The case study data base contains the information utilized throughout the study, including documents reviewed, meeting summaries, interview notes, and other materials utilized in this study. If the same study was done with the information contained in the case study data base, the same results should be achieved.

Ethics is a subject that must be addressed in all research. Although no specific data will be collected on individuals, the potential for the use of information to give one organization an information advantage over the other exists. To address this ethical issue, I plan to remain objective throughout this study, and will remove myself from decision making processes related to this case. This role was approved by the GLWACH leadership and participation in the case on a decision making level was not required. By establishing this role early, I was able to preclude any questions about my loyalty to my organization.

## LITERATURE REVIEW

Health care executives cannot read a health care journal in today's environment without being constantly bombarded with the three maxims of cost, access, and quality. These issues have never had more exposure or emphasis than they have in the past year. This was driven primarily by the emphasis placed on health care by the Clinton Administration in their attempt to pass legislation enacting Health Care Reform. However, the Clinton Administration did not just identify these problems with health

care in America, they have been known for years. With 14% of the gross national product devoted to health care, approximately 37 million people uninsured, and health levels that measure below those of other countries that spend less on health care, public scrutiny of our health delivery system is not unwarranted.

The leadership of the two largest federal health care delivery systems in the U.S., the Veteran's Affairs and the MHSS, are deeply involved in tackling the cost, access, and quality problems within their organizations. The Army Medical Department (AMEDD) even has an award called the Triangle Plus Award for facilities that have taken steps to improve in five critical areas. Three of these areas are cost, access and quality (HSC Commander's Notes 94).

The DOD Tricare concept is another example of the MHSS resolve in addressing the major issues of the industry. Each Tricare regional contract will be designed to optimize the use of all direct care assets in the region through the development of a single, integrated health care network (Anderson 1994). Optimizing the use of available assets will allow medical treatment facilities (MTFs) to better manage the care provided to beneficiaries. By exercising increased control over the management of care, MTFs will be in a better position to make decisions that are congruent with the policies and goals of higher headquarters. The cost effectiveness of Tricare lies in the ability of the MHSS to operate their direct care system more cost effectively than nonmilitary alternative sources of care such as CHAMPUS (United States General Accounting Office 1994).

The Veteran's Affairs leadership is also taking steps to deal with the three major issues in health care. Veteran's Affairs Secretary, Jesse Brown, has addressed each of these issues in his Secretary's Vision which states "We will function as a unified Department delivering benefits and services in a high quality, cost effective, and timely manner to serve veterans and their families" (Annual Report of the Secretary of Veterans Affairs 1993). Increasing access to health care is one of Secretary Brown's top priorities (Weissenstein 1993). After personally fielding routine calls from a Chicago VA customer service office, Secretary Brown even called upon VA medical facilities to assign veterans to health care teams. These teams would be the sole point of contact for veterans and their families (Adde 1994). Secretary Brown appears to be putting a personal emphasis on health care priorities for the VA.

Many health care executives believe that their industry is distinct and cannot utilize methods used in other industries to address problems and develop strategies. Although the health care industry is distinct in the services it provides, there are many similarities that it has with other service industries in general. Problems with overcapacity, shortage and maldistribution of resources, and consolidation are just a few examples of problems that are common in many industries. Many of the goals may also be common, such as increased quality and a strong customer focus (Sherer 1994). Health care executives should identify problems and goals that are common with other industries and seek out ideas and strategies that have proven successful, as well as identifying strategies that have failed. This method will allow executives to learn from the mistakes of others while adding to their own list of strategies available for use.

One strategy that has been used in many industries is the combining of forces to meet common objectives. The DOD and the VA have done this in hundreds of cases under the umbrella of the VA and DOD Health Care Resources Sharing Program. Under this program the medical facility directors are to pursue sharing agreements with their VA or DOD counterparts that result in increased quality, improved services, and improved cost control. Sharing agreements are not to result in delay or denial of service, reduced accessibility, or decreased quality of care for beneficiaries of either Department (MOU 1994).

The opportunities for resource sharing between the VA and DOD are limited only as stated above. This fact opens the door for virtually any ideas that are beneficial for the participating organizations. Examples of agreements range from simple referrals, to the military operating a large inpatient ward in a VA hospital. Joint construction projects have also been executed (Simmons 1989).

#### DESCRIPTIVE DATA

##### Facility Demographics

GLWACH is a 75 bed community hospital located in south central Missouri. The catchment area population supported by GLWACH is approximately 36,658 people. The population can be stratified into active duty military personnel which total 10,773, and a non active duty population of approximately 25,885. Additionally GLWACH is responsible for providing health care to beneficiaries within a radius of approximately 40 miles surrounding Fort Leonard Wood. The majority of the

workforce at Fort Leonard Wood serves the U.S. Army Engineer Center and School, which is located at Fort Leonard Wood. Another major mission of Fort Leonard Wood is to conduct Basic Training for enlisted personnel entering active duty. Additionally, plans are being made to move the Army Chemical School and the Army Military Police School to Fort Leonard Wood.

Harry S. Truman Memorial Veteran's Hospital is a 210 bed Medical Center located in Columbia, Missouri, approximately 105 miles from GLWACH. The VA has a beneficiary population of approximately 23,600 in the seven county region surrounding GLWACH (Annual Report of the Secretary of Veterans Affairs 1993).

The UMHSC operates a 400 bed hospital serving primary, secondary and tertiary health care needs. Approximately 15,000 patients are admitted to the University Hospital each year. Medical services are provided in more than 60 specialties and subspecialties. UMHSC has more than 250 physician members and more than 300 resident physicians. UMHSC also operates the only helicopter ambulance service in mid-Missouri (UMHSC 1993). The hospital operated by the UMHSC is located directly across the street from the VA in Columbia, Mo.

The VA and the UMHSC have a close affiliation, with many of the physicians serving patients in both facilities. Many of the VA providers serve as faculty for UMHSC. Additionally, these two facilities operate the largest shared laboratory service in the VA hospital system. The facilities are even connected by an underground tunnel (Townsend and Lucas 1979).

### DOD Resource Sharing

To solidify the proposed relationship, GLWACH and the VA may enter into an agreement that falls under the concept of the Department of Defense (DOD) Sharing Agreements. It is unclear at this point, if the UMHSC will be able to somehow work into a DOD Sharing Agreement, or if they will be dealt with independently as a non-federal entity.

The office of the Assistant Secretary of Defense for Health Affairs (OSD (HA)) and the Veteran's Affairs, have agreed to the sharing of resources in continuing attempts to control the escalating costs of health care. By each contributing resources to accomplish a specific mission, a synergistic effect is possible that will allow for the benefit of each of the federal organizations and ultimately the U.S. Government and the taxpayers. By effectively utilizing resources contributed from separate organizations, economies of scale and scope may be achieved, while at the same time improving access and maintaining quality. GLWACH plans to take this logic one step further by including the UMHSC.

The concept of resource sharing is not new, but has been constrained by legal restrictions over the way the OASD (HA) and the Veteran's Affairs were allowed to operate. Many of the roadblocks that hindered resource sharing in the past have been bypassed with new legislation and Memorandums of Agreement between the Army and the VA. The Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, Public Law 97-174, was enacted in 1982. It was designed to promote greater sharing of health care resources and achieve increased

efficiencies within the health care systems of the VA and DOD. This law authorized active duty beneficiaries and other eligible former service members to receive care in VA facilities, and VA beneficiaries to receive care in DOD facilities. This initial legislation did not authorize the DOD to use CHAMPUS funds to reimburse the VA. However, legislation to make this change was passed in 1989. Additionally, Public Law 97-174 did not allow the VA to treat dependents of active duty. This too was changed in 1992 (United States Government Accounting Office 1994).

With legislative roadblocks out of the way, an open road awaits the DOD and VA facilities that can work together to enhance the benefits to both organizations and beneficiaries. Throughout the period of this study, ongoing dialogues were maintained between participating organizations in order to identify and define the needs and contributions each organization will bring to this new consortium. Currently, GLWACH and the VA both have planning teams doing groundwork to identify specific needs and areas of excess capacity that would work best in the proposed arrangement.

#### Veteran's Affairs Primary Care Clinic

One major objective of GLWACH and the VA, is to open a Veteran's Affairs Primary Care Clinic (VAPCC) at Fort Leonard Wood. Initial discussions revolved around the VA using an existing building located on the post to serve as the VAPCC facility. The VA would provide staffing, supplies and equipment, and GLWACH would provide ancillary support as required. Ancillary support at this time will include lab, x-ray, and pharmacy.

Upon touring the building identified to house the VAPCC, the VA leadership did not appear to be very enthused about continuing with the idea of using the proposed building. The building was too old, it was in a poor state of repair and it was located too far from ancillary support. Additionally, the proposed building was located in the center of a troop billeting area of the installation, which did not facilitate a smooth transportation route. Conversation migrated from the original building proposed, to potential use of a new Consolidated Troop Medical Center (CTMC) being constructed on post, and finally to the possibilities of operating a clinic within the main facility of GLWACH.

Subsequent discussions about staffing specifics began to cause some concerns about the difficulty in providing a primary care physician to work in the VAPCC. Neither the VA or the UMHSC seemed excited about having to provide a primary care physician to operate over 100 miles away from their main facilities. This was further complicated by the fact that the facility is medically isolated, and is in a very rural part of the State. GLWACH's poor success rate at recruiting physicians to the area in the past, seemed to highlight the fact that physician coverage of the VAPCC would have to come from the staff of one of the participating organizations. Staffing at GLWACH, did not allow for the option of using a GLWACH provider in the clinic. Physician staffing materialized as a major issue that must still be dealt with.

### Incentives for the Consortium

The concept of a consortium of services provided by GLWACH, VA, and the UMHSC is enticing, but leaves many questions to be answered. One of the main questions that come to mind is; What are the incentives for these organizations to join forces in this endeavor?

It is anticipated that the proposed joint venture would provide a synergistic effect that will improve in the three critical areas of cost, access, and quality. There will be differing effects in each of these areas, for each individual facility choosing to participate. Additionally, a consortium will give the conjoined organizations a stronger position from which to deal with the competition and to develop strategies to best take advantage of strengths, and opportunities while controlling weaknesses and threats (Duncan, Ginter and Swayne 1992).

Incentives for GLWACH and Fort Leonard Wood to support a VAPCC on the installation are the benefits that would be obtained from having another federal agency functioning at Fort Leonard Wood. In a briefing to the civilian workforce of Fort Leonard Wood, the Commanding General stated that it is key to the installations survival to bring business to the installation (Ballard 1995). Additionally, this consortium provides for an increase in community focus, specifically on health care. It would make a very positive statement about GLWACH's commitment to the health of the veteran and the community in general.

Some personnel that are eligible for care at GLWACH may also be eligible for care at the VA (dual eligibles). When the VAPCC becomes operational, dual eligibles

will have a choice of where they want to receive medical care, without driving to Columbia. The proposed VAPCC potentially creates opportunities for continued care being available for retirees. Continuity of care is another benefit to the eligible population.

If dual eligible beneficiaries choose to go to the VAPCC, this could prove to be financially beneficial to GLWACH. GLWACH is financed under a capitated system, and is provided a set amount of capital based on its' beneficiary population. The same funding is provided regardless of where the beneficiaries receive their health care. If sufficient numbers of dual eligible beneficiaries utilize the VAPCC, more funds may be freed for use in other discretionary areas.

Initial discussion with the VA leadership, about the consortium, included mention of a possible transportation system from Fort Leonard Wood to the VA. If this system becomes a reality then GLWACH may also be able to utilize this system. This is even more appropriate since the VA has a preferred provider contractual relationship with GLWACH.

Other incentives include: the emphasis that DOD placed on resource sharing agreements; the additional workload for ancillary services may help to justify staffing levels during benchmarking; and there may be opportunities to share data systems with the VA.

The VA's incentives are similar to GLWACH's in that the leadership at the VA is also stressing the use of DOD resource sharing agreements. The proposed VAPCC would also help to solidify their relationship with GLWACH. The VA's primary reason

for opening a VAPCC at Fort Leonard Wood appears as an attempt to be more responsive to their patient's needs. This is exhibited several ways with this initiative. First, VA beneficiaries can avoid the drive to Columbia if they so desire. The low number of providers staffing the VAPCC will also be more amenable to continuity of care.

VA beneficiaries may be more likely to seek help for minor illnesses if a primary care clinic is within a relative short driving distance as opposed to driving long distances. This could help in identifying serious medical problems earlier, and thereby potentially avoid the extensive treatments and associated costs of medical problems not identified until later stages of the disease process. This is beneficial to the VA, the patient, and the community in general.

VAPCC patients may be able to utilize GLWACH's new Health Promotion Center (HPC). The HPC is designed to educate beneficiaries on self care, early intervention of the disease process, and promotes change toward a healthy lifestyle. The HPC has a large selection of written materials and video tapes. Materials can be checked out or viewed in private viewing rooms. Additionally, a large selection of health promotional classes are offered to patients both on a referral and walk-in basis.

Along these same lines, the VAPCC may be utilized as an additional location to execute the VA's Preventive Medicine Program which began in 1985. This program has identified diseases that have a high mortality and morbidity in the VA beneficiary population. Eleven risk factors, interventions or services that focus on these diseases, are at the heart of this prevention program (Annual Report of the Secretary of Veterans

Affairs 1993). The proposed VAPCC fits nicely into Secretary Brown's increased emphasis on prevention and his new push towards outpatient care (Adde 1995).

The consortium of services provided by the participating organizations will also help solidify relationships between the facilities. In today's environment, a consortium is an option being taken by more and more facilities. It can be viewed as a strategic move to form alliances that will produce the increased strength and flexibility needed to deal with competitors and to operate within the dynamic environment of the health care industry (Duncan, Ginter and Swayne 1992).

This type of arrangement also provides an opportunity for increased quality of services. Participants can draw upon each others expertise for guidance and referral in both clinical and administrative areas. Additionally, alliances provide opportunities to shift workloads, take advantage of excess capacity, and facilitate reduced compensation arrangements.

GLWACH is relatively isolated and sends its referral patients to Fitzsimmons Army Medical Center (FAMC), located in Aurora Colorado, when the patient's condition allows for the additional time required for an extended trip, and when the required services are available at FAMC. Patients whose conditions are not appropriate for transfer to FAMC are sent to preferred providers that are in closer proximity to GLWACH, or to facilities that have the expertise needed for the patient's condition. Evacuation is conducted by both air and ground vehicles, as conditions require.

Routine patient evacuations from GLWACH to FAMC are conducted by the Air Force's Aeromedical Evacuation System. Twice a week an aircraft lands at Ft. Leonard Wood to transport GLWACH patients to FAMC in Denver. The system operates at no cost to GLWACH. However, according to Col Kenneth Steinweg, Commander of GLWACH, "the air evacuation system is under tremendous pressure to reduce operations" (Steinweg 1995). The elimination of this service would provide a critical hardship on GLWACH to establish an affordable alternative evacuation system.

The ability to send referral patients 105 miles to Columbia for tertiary and specialty care would create new transportation problems, but is undoubtedly more desirable than sending them 800 miles to FAMC. This point is even more critical to the planning process, as FAMC was recently identified as a facility recommended for closure by the Base Realignment and Closure Commission (BRAC). FAMC has been a prime candidate for closure for the past several years. It appears that the only reason it has remained open this long, is because of the political clout of Colorado politicians. By establishing a referral base in Columbia, GLWACH is preparing itself for the discontinuance of services provided by FAMC and the possible discontinuance of the Air Force Aeromedical Evacuation System.

UMHSC will undoubtedly attempt to work GLWACH into their emerging telemedicine initiatives in an effort to benefit both organizations. A three year, \$1.2 million project to study delivering specialty and emergency consultations over telephone lines at UMHSC is being funded by the U.S. Health Resources and Services Administration (HRSA). The project includes the use of still and interactive video

images from primary care providers to the Health Science Center. This initiative is expected to increase access and keep health care local; a concept that supports all participating organizations climates (Missouri Department of Health 1995).

Reimbursements for services that are not provided in person is an associated topic that must be addressed. Telemedicine is so new that legislators and insurers are still struggling with how to handle billing and reimbursements for services that are not provided in person. Legislation is expected to reach congress within the next year (Missouri Department of Health 1995).

#### Implications of Tricare

The impending Tricare Health Services Support Contract will provide MHSS beneficiaries with the option of enrolling in an HMO type health care plan entitled Tricare Prime, a preferred provider type plan entitled Tricare Extra, or an indemnity fee-for service option that is similar to the current standard CHAMPUS program (United States General Accounting Office 1994). With the offering of these different health plans, MHSS beneficiaries will have the ability to decide where they will receive their health care. If they are to remain viable, military treatment facilities (MTFs) must make a concerted effort to ensure beneficiaries see them as a facility that can efficiently and effectively meet their health care needs. The proposed consortium of health care capabilities is one way GLWACH can remain an attractive alternative to its local beneficiaries.

Customer satisfaction is extremely high at GLWACH, as evidenced by a 1994 DOD satisfaction survey report. GLWACH placed first in TRADOC and sixth overall, in a survey of all Army hospitals (MEDDAC Bulletin 1994). However, if GLWACH is to maintain and improve this level of satisfaction among its beneficiaries, its leadership must take innovative measures, such as the proposed consortium, to maintain the patient population that now chooses to receive health care services at GLWACH..

GLWACH needs to achieve the conceptualized seamless congruence of primary, secondary, and tertiary health care services with the identified health care organizations prior to the implementation of the Tricare contract. If this goal can be realized, the contractor will only be needed for services that do not fit into the system designed by the participating organizations. By maintaining the patient population that currently and prospectively will utilize GLWACH, the capitation funds that go along with the mission to provide health care to this same population are also being preserved.

If GLWACH cannot retain its patient population, one possible consequence could be decreased funding and consequently diminished service to beneficiaries. As services are reduced, patient satisfaction may also diminish. This may lead to further reductions in patients choosing GLWACH as their primary health care facility. At the bottom of this anti-selection spiral, will be a position where GLWACH only provides health care to active duty soldiers, as required by law. All other potential customers will have chosen other options. This bleak scenario may not be too far from reality if MTF leaders do not take innovative steps to remain viable organizations.

## ANALYSIS

It is plausible to expect that the consortium of health care contemplated by GLWACH, VA, and the UMHSC will improve access to both GLWACH and VA beneficiaries. If the VA opens a VAPCC at GLWACH, dual eligibles will have the choice of which system to use, the MHSS or the VAPCC. This should increase access for the dual eligibles. Additionally, having referral services available in Columbia as opposed to FAMC has advantages both in proximity and availability. Developing a referral source appears as a necessity, be it with Columbia or another tertiary care facility, considering the elimination of FAMC and the potential loss of the evacuation system that transports GLWACH patients to FAMC.

GLWACH can also expect to benefit from a reduction in CHAMPUS costs. These results are expected due to several factors. First, the closer proximity to the participating facilities should allow for much more intense management of patients being referred for secondary and tertiary care. Second, the consortium should result in an agreement that allows for a reduction in the price of services, or an exchange of services as recompense.

This arrangement should not cause a decrease in the quality of service provided by the organizations in this consortium. The VA recently outscored their civilian counterparts by 10 points on a scale of 1 to 100, in 1991 reviews by the Joint Commission on Accreditation of Healthcare Organizations (Findley 1992). The solidifying of relations between providers at participating facilities may actually allow for an increase in the quality of services provided. As providers learn each other's

strengths and weaknesses, they will be able to form a network that provides improved services for the patient. Specific provider expertise may become more readily available.

## CONCLUSIONS

The proposed consortium of services between these organizations appears to be one that is driven partially out of necessity for GLWACH. With the discontinuance of one and potentially two Federal services that are an intricate part of how GLWACH provides health care to its' beneficiaries (FAMC and the Air Force evacuation system), it is essential to establish an alternate method of providing these services. Even if this consortium does not come to fruition, it is necessary to establish a backup to the current system.

Even if the Federal services in question were not being considered for elimination, the proposed consortium would still appear to be an attractive option for GLWACH, and the VA. By working together, the Veteran's Affairs and the DOD will be better able to utilize limited federal resources more efficiently. The veteran serves as a natural link between these two systems, and because both the VA and DOD want to provide the best possible services, the joining of forces to achieve a common goal makes sense.

Market pressures also play a large part in the design of this agreement. With more and more health care organizations joining forces to be able to compete in the managed care environment, it is becoming increasingly difficult for independent organizations to wield enough power to allow them to operate as efficiently as possible.

By developing this consortium, a network is being formed that will allow the participating organizations to exert much more influence than they previously could independently. The concept of the joining of forces to achieve a common goal has recently become a very popular alternative throughout the entire health care industry. Over 2,100 joint ventures occurred between 1989 and 1993 (Danzon 1994).

The potential advantages of improved efficiencies are another reason this agreement should be pursued. By taking advantage of each other's excess capacities and shortages, both the DOD and the VA are meeting the intent of policies on resource sharing. The current environment of increased emphasis on cost control and efficient use of limited resources are significant issues in this case.

The communities of these hospitals also stand to benefit from this consortium. There has been a recent increase in the focus on hospital responsibilities to the community (Coile 1994). This agreement can be viewed as a positive step that is responsive to those who question the loyalty of hospitals to the communities they serve.

Establishing a transportation system and coordinating the planning, implementation and execution of the agreement are the major costs associated with this consortium. Opening a VAPCC in the GLWACH facility does not incur any significant costs to the facility, as the excess space is available. The ancillary support to this clinic could be viewed as costs, but will more than likely be offset by services provided to GLWACH as a means of reciprocation. The high fixed costs paid by GLWACH will not be affected by a small increase in volume associated with a VAPCC. Determining

the source of, and providing a primary care physician appears to be an obstacle that may have associated costs at this point.

It appears that participating hospitals are examining both their external and internal environments and evaluating their alternatives. After reviewing this case, I believe that the consortium should be developed and executed as part of a strategic plan that will have an impact on the overall viability of participating hospitals.

This study may be utilized by the leadership of GLWACH as a factor in making future decisions about this consortium. Results may also be useful to MTF leaders throughout the military as they ponder their strategic options on DOD/VA sharing agreements and joint ventures.

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